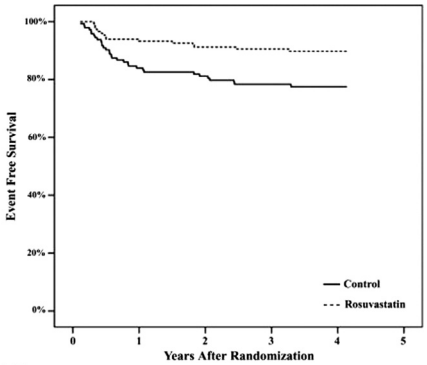
OP-093

ROsuvastatin LOading and Clinical Outcomes (ROLOCO) Trial

Serkan Çay[1], Fatih Uçar[1], Göksel Çağırcı[2], Serkan Topaloğlu[1], Dursun Aras[1], Sinan Aydoğdu[1]
[1]Turkiye Yuksek Ihtisas Hospital, Ankara, [2]Antalya Training and Research Hospital, Antalya

Background: Pre-procedural administration of statins has been found to be associated with reduced peri-procedural myocardial injury and infarction.
Aim: The aim of the present study was to evaluate the effect of pre-procedural single high loading dose (40 mg) of rosuvastatin on the primary end-points of all cause mortality and composite of death or myocardial infarction from cardiovascular (CV) causes, target vessel revascularization (TVR), or stroke.
Methods: Two hundred ninety nine statin-naive patients with stable ischemic heart disease (SIHD) and de novo lesions appropriate for PCI were randomized to rosuvastatin-treatment (n=153) and to no-treatment (n=146) groups. A 40 mg loading dose of rosuvastatin was administrated 24 h before the PCI. Four-year follow-up period was planned (long-term follow-up of previously published study).
Results: A total of 290 (97%) patients (147 rosuvastatin and 143 no-treatment) completed the study. The median age was 62 years. Male was 70% and 18% of patients had diabetes and 43% had hypertension. Previous MI and PCI/CABG history were present in 27% and 39% of patients, respectively. The primary end-point of all cause death and composite of death or myocardial infarction from CV causes, TVR, or stroke was lower in the rosuvastatin group compared with the no-treatment group (10.2% vs. 22.4%, p=0.005), driven by a reduction in TVR (6.1% vs. 13.3%, p=0.039).
Conclusion: Among patients with SIHD undergoing PCI, pre-procedural administration of single high loading dose of rosuvastatin was associated with a reduction in major adverse cardiac and cerebrovascular events (MACCE) at 4 years, driven primarily by a reduction in TVR.



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OP-094

Percutaneous Mitral Valve Repair with the MitraClip System for Severe Mitral Regurgitation: First Experiences in Turkey

Mehmet Bilge[1], Sina Ali[2], Ayse Saatci Yasar[2], Recai Alemdar[2], Özgür Kırbas[2], Özge Kurmus[2], Turgay Aslan[2], Cemal Koseoglu[2], Bilge Karaduman Duran[2], Mehmet Erdogan[2], Mustafa Duran[2], Serkan Sivri[2], Zeynep Seyma Turinay[2]
[1]Yildirim Beyazit University, Faculty of Medicine, Division of Cardiology, Ankara, [2]Ataturk Education and Research Hospital, Division of Cardiology, Ankara

Introduction: Percutaneous mitral valve repair using Mitraclip has recently emerged as an alternative to surgery for the treatment of severe mitral regurgitation (MR). The purpose of this study is to describe the initial experiences in Turkey with the MitraClip system.
Methods: Twenty patients with severe MR underwent treatment with the MitraClip in our center. Preoperatively, all the patients underwent a standardized protocol, which included transesophageal echocardiography (TEE), angiography and evaluation of the surgical risk. With the patient under general anaesthesia and using fluoroscopic and TEE guidance, the MitraClip device was introduced into the left atrium via the transfemoral venous route and transseptal puncture. The MitraClip system was directed towards the origin of the regurgitant jet and advanced into the left ventricle. The clip was retracted until both leaflets were grasped and then closed to coapt the mitral leaflets. Device success was defined as placement of 1 or more MitraClip with reduction of MR to ≤2+.
Results: From July 2012 to June 2013, 20 patients with severe MR with a mean age of 62.4± 12.6 years (15 males and 5 females; mean logEuroScore 24.1±11, mean LVEF 26.1±10.3%) were treated with the MitraClip. Of the 20, 18 (90%) had functional MR (ischaemic in 14 patients; dilated cardiomyopathy in 6 patients), one had papillary muscle rupture due to acute myocardial infarction and the other had spontaneous papillary muscle rupture. Before the procedure, average left ventricular ejection fraction, left ventricular diastolic and systolic diameters and systolic pulmonary pressure were 26.1±10.3%, 64±9 mm, 54± 11 mm and 62±18 mmHg, respectively. Acute procedural success rate was 90% (n=18). In two patients (10%), we were unable to grasp the leaflets and no clip was deployed. Fifteen patients (75%) received one device, 3 patients (6%) received two devices. The clip was implanted in the central portion of the valve in 16 (80%) of patients. In two cases (10%), the clip was implanted in the lateral scallops. Post-procedural MR severity was reported as MR ≤2+ in 90% of patients, with 44% of all patients achieving MR ≤1+. The procedural mortality was 0%. No patient underwent emergency cardiac surgery for a failed clip implantation. Cerebrovascular event, acute myocardial infarction, clip detachment or embolization and site bleedings did not occur in any patients. In only one case, immediately after the guide catheter removal from the interatrial septum, TEE demonstrated a mobile thrombus seemed to be attached to the interatrial septum at the septal puncture site. The patient was managed with anticoagulation because of the high-risk nature of surgery. The TEE performed on the 5th postoperative day demonstrated no thrombus. The median device time was 100 minutes.
Conclusion: Our initial results shows that MitraClip could be safe, feasible and effective treatment in severe MR.

OP-095

Percutaneous Mitral Repair with the MitraClip System in Patients with Moderate and Severe Heart Failure

R Gökmen Turan, Ilkay Bozdag Turan, Liliya Paranskaya, Ralph Birkemeyer, Stephan Kische, Ibrahim Akin, Jasmin Ortak, Jan Schubert, B. Westphal, Christoph A. Nienaber, Hüseyin Ince
Department of Internal Medicine, Division of Cardiology, Rostock-University, Rostock, Germany

Aims: Edge-to-edge repair of mitral regurgitation (MR) with the MitraClip® system is increasingly applied in advanced heart failure. Our objective was to compare outcomes in patients with moderate and severe systolic heart failure.
Methods-Results: Between February 2010 and July 2012, 121 patients with MR of at least grade 3+ and a mean EuroSCORE II of 10.6% underwent MitraClip® implantation. 39 had a left ventricular ejection fraction (LVEF) of ≤30% (group A) and 82 of >30% (group B). Procedural success was comparable in both groups (100% vs 95.2%) with multiple (>2) clip implantation in 34% respectively 25% of patients. At 12 months absolute reduction of MR grade (2.3 vs. 2.2) and relative reduction of mitral valve orifice area (48% vs 42%) was also comparable. LVEF parameter and NYHA class had improved significantly 12 months after MitraClip treatment in both groups compared to baseline (Figure 1). In-hospital mortality was low in both groups (2.6% vs 2.4%) but there was a strong trend for higher 12-month mortality in group A (34 % vs 18 %, p=0.05) with no significant difference in the overall rate of major adverse cerebrovascular and cardiac events (36.8% vs 28.9%, p=0.38). On multivariate analysis MR grade after repair was the strongest predictor of mortality (OR 2.121, 95% CI 1.095-4.109) whereas systolic impairment was no independent predictor.
Conclusion: Percutaneous mitral valve repair led to comparable symptomatic improvement in patients with moderately or severely reduced LV function. LV-EF < 30% was no independent predictor of short term mortality which was mainly governed by residual MR after repair.